Recovery/Treatment Plan ☐ **Initial or** ☐ **Update**

Client Name: _____ **Primary Counselor:** _____

Client ID# _____ **Admission Date:** _____

PROBLEM	GOAL	*S=Short Term L=Long Term*	ACTION PLAN *(include frequency)*	RESPONSIBLE *C=Client P=Program*	TARGET DATE	RESOLUTION DATE
1.						
2.						
3.						
4.						

Client's Name (Printed): _____ **Client's Signature:** _____ **Date:** _____

Counselor's Name (Printed): _____ **Counselor's Signature:** _____ **Date:** _____

SUD & Significant Associated Diagnosis (DSM/ICD-10 Code): _____

MD REVIEW Name* (Printed): _____ **MD Signature*:** _____ **Date:** _____

Program Manager Name (Printed): _____ **PM Signature:** _____ **Date:** _____

***MD printed name/signature is required within 15 days of Counselor's signature & date for Drug Medi-Cal billing**